MIAMI-DADE COUNTY MEDICAL EXAMINER DEPARTMENT
NUMBER ONE ON BOB HOPE ROAD
MIAMI, FLORIDA 33136-1133
(305) 545-2422 / 545-2472 / FAX: (305) 545-2409

PUBLIC INTERMENT PROGRAM

AUTHORIZATION FOR CREMATION AND DISPOSITION

DATE: _____/_____/_____
M D Y

_____
NAME OF DECEASED

I/We, the undersigned, hereby request, authorize and direct Miami-Dade County to cremate the above named remains in accordance with, and subject to the Florida Statutes governing Crematories/Direct Disposers.

I/We understand that Florida Law authorizes the disposal of unclaimed cremains after 120 days from the date of cremation.

I/We agree to indemnify, release and hold Miami-Dade County, its agents and employees harmless from any and all loss, damages, liability or causes of action (including attorney's fees and expenses of litigation) in connection with the cremation and disposition of the cremated remains of the deceased, as authorized below:

SIGNATURE OF PERSON(S) AUTHORIZING CREMATION AND DISPOSITION

_____ _____
Print Name Relationship to Deceased

_____
Signature

ADDRESS: _____ Tel. No. ( ) _____

☐ PER TELEGRAM OR FAX

WITNESS:

_____
Print Name

_____
Signature

ADDRESS: _____ Tel. No. ( ) _____

CREMAINS DISPOSITION:

_____ Return to authorized Person
_____ Scatter as Appropriate